

## SNF Help File Purpose, Description and Coding May 25, 2003

The purpose of the SNF Help File is to provide guidance to intermediaries, carriers, SNFs, and suppliers on which HCPCS codes are included in the SNF PPS rate, which may be paid separately, and who may submit claims for services that can be paid separately.

### Specific Purpose

The file has two purposes.

1 - To define by HCPCS code whether the service is considered included in the Part A SNF PPS rate, and

2- For outpatients and for residents for whom Part A payments cannot be made (e.g., benefits exhausted, non covered level of care, no Part A entitlement), to describe the following items related to the Part B billing for the service.

- Whether the SNF can bill the service,
- Whether the HCPCS code for the service requires a modifier, and
- How the service is priced and paid by the intermediary.

### What the File Contains

The following data elements are shown.

**HCPCS Code** - The HCPCS numeric or alphanumeric code.

**HCPCS Description** - The approved short description for numeric codes or the long description for alpha-numeric codes.

**HCPCS Description**

**Whether Service Included in Part A PPS Rate**

**Part B Coverage Status Manual Reference**

**Part B PC/TC Indicator**

**Part B Price Method**

**Part B Price Code**

**Comments**

### Included in Part A PPS Rate

A “YES” indicates that the service is included in the PPS rate. A “NO” indicates that it is not. A “COM” means special rules apply that are described in the Comments field. Services provided to a Part A resident are included in the SNF PPS rate. They may not be billed separately by the SNF or by any other provider or supplier. This would be duplicate billing.

The remainder of the table data relates to Part B payment.

Some services excluded from the Part A PPS rate may be separately billed by the SNF or by another entity that provides the service. Also, if the service is not paid under PPS, because Part A payment could not be made (e.g., the beneficiary not entitled to A, benefits exhausted, noncovered level of care, etc;) Part B payment may be possible.

Part B Coverage Status Manual Reference - Shows where the service is discussed in CMS manuals.

**Part B PC/TC Indicator** - This is an indicator that CMS uses to inform carriers and intermediaries about the characteristics of the services described by the code with respect to whether the service is a physician component or a technical component, or whether a modifier is required on the code to describe the component. A number of HCPCS codes may include a service such as a test and related equipment that is considered a non physician service or technical component, and may also include a physician service such as interpretation of the test. In general, claims for physician services are processed by the carrier, and technical component is processed by the intermediary. Other HCPCS codes are for physician component or for the technical component.

Following are the PC/TC codes that CMS uses and the related processing guidelines for intermediaries.

Generally, SNFs may bill only for covered SNF services with TC/PC codes with indicators of 3,5,7,9 and may bill for TC/PC indicator 1 with modifier TC.

However, explicit instructions may state otherwise, e.g., the SNF must bill all rehab codes and some surgery codes, and some codes are defined as rehab that the SNF must bill, and as surgery codes the SNF is not required to bill depending upon related services provided.

### **Code Values for PC/TC Indicator PT B**

**0 - Physician Service Code:** Codes with a 0 indicator are not considered to have a separately identifiable professional or technical component. They are not billed with a TC or 26 (PC) modifier. Intermediaries reject the service unless an exception is stated in the comments field (e.g., rehab) and notify the SNF to request the physician to bill the carrier. Physicians submit these services to the carrier for processing and reimbursement.

**1 - Diagnostic Tests or Radiology Services:** An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. A SNF can bill only for the TC component and must use the TC modifier (e.g., G0030TC). If a global code is submitted, e.g., G0030 with no modifier, FIs reject the service and notify the SNF to resubmit only the TC. If modifier 26 (PC) is submitted, FIs reject the service and notify the SNF that the professional component must be billed by the physician to the carrier.

**2 - Professional Component Only Codes:** Codes with an indicator of 2 signify services that only have a PC. Intermediaries reject these services and notify the SNF that the service must be billed to the carrier.

**3 - Technical Component Only Codes:** Codes with an indicator of 3 signify services that have only a TC. Intermediaries pay these without a modifier, unless specifically noted otherwise in the help file.

**4 - Global Test Only Codes:** Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service. FIs reject the service and notify the SNF to resubmit the service using the code that represents the TC only.

**5 - Incident To Codes:** These codes normally are not considered physician services in the SNF setting. The SNF may bill these codes to the intermediary without a TC modifier (except for the codes identified as not billable by SNFs).

**6 - Laboratory Physician Interpretation Codes:** These codes are for physician services to interpret lab tests. Intermediaries do not pay for these services. They reject the service and notify the SNF that the services must be billed to the carrier. Considered a billable physician service and may be paid by the carrier to the physician. There are none of these codes shown on the help file.

**7 - Therapy Services:** These services are only billable by the SNF to the intermediary. The TC modifier is not needed. Note that other modifiers may be required under the therapy fee schedule. These are not described here. Note that some codes are not considered to be rehabilitation (therapy) services when delivered by a clinical psychologist, psychiatrist, or clinical social worker, for treatment of a psychiatric condition. These are identified.

**8 - Physician Interpretation Codes:** An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 85060, and P3001-26. A TC indicator is not applicable. Intermediaries do not pay for these services. They reject the service and notify the SNF that the services must be billed to the carrier. Carriers reimburse the physician for these codes when submitted.

**9 - Concept of a Professional/Technical Component Does Not Apply:** An indicator of 9 signifies a code that is not considered to be a physician service. See the comments column to determine who may bill.

## **Part B Price Method**

This column describes the Part B price method. Possibilities are fee schedule, reasonable cost, a payment rate, a payment limit, or price established by an individual carrier (including reasonable charge and individual consideration). Charges for reasonable cost items should be listed as Medicare charges on the SNFs cost report. Other items are considered final payment and are not listed as Medicare charges. Note that this column applies to SNFs only.

## **Part B Price Code (alphanumeric codes only)**

The pricing code from the CMS system that identifies pricing methodology for alphanumeric codes -00 - Service not separately priced by Part B (e.g., services not covered, bundled, used by Part A only, etc.)

### **Physician fee schedule and non-physician practitioners**

11 - Price established using national relative value units (RVU's)

12 - Price established using national anesthesia base units

13 - Price established by Carriers (e.g., not otherwise classified, individual determination, Carrier discretion)

### **Clinical Lab Fee Schedule:**

21 - Price subject to national limitation amount

22 - Price established by Carriers (e.g., gap-fills, Carrier established panels)

31 - Frequently serviced Durable Medical Equipment (DME) (Price subject to floors and ceilings)

32 - Inexpensive and routinely purchased DME (Price subject to floors and ceilings)

33 - Oxygen and oxygen equipment (Price subject to floors and ceilings)

34 - DME supplies (Price subject to floors and ceilings)

35 - Surgical dressings (Price subject to floors and ceilings)

36 - Capped rental DME (Price subject to floors and ceilings)

37 - Ostomy, tracheostomy, and urological supplies (Price subject to floors and ceilings)

38 - Orthotics, prosthetics, prosthetic devices and vision services (Price subject to floors and ceilings)

45 - Customized DME items

46 - Carrier priced (e.g., not otherwise classified, individual determination, Carrier discretion, gap-filled amounts)

### **Other**

51 - Drugs

52 - Reasonable charge (also used for reasonable cost, and for rate for ambulance services before implementation of the ambulance fee schedule)

54 - Vaccinations

57 - Other Carrier priced

99 - Value not established

### **Comments**

Comments include additional information, such as the effective date for the code or policy, and any restrictions on what provider/supplier types might be allowed to bill for the HCPCS code.